Clinical Section

Recent Advances in Medicine*

By

F. GERARD ALLISON, B.A., M.D. (Man.)
M.R.C.P. (Lond.)

Demonstrator in Medicine, University of Manitoba
Assistant Physician, Winnipeg General Hospital

This subject can be discussed under the following headings: Drug therapy, reversals in treatment, and advances in technical methods.

Drug Therapy

Sulphanilamide Compounds. These drugs constitute, in my opinion, the greatest therapeutic advance in this century. Sulphanilamide itself is effective against the haemolytic streptococcus, meningococcus, gonococcus, B. coli, actinomyces, malarial parasites and the infective agent in trachoma. Patients with severe infections are given approximately 75 gr. a day, attempting to reach a blood level of 10 mgm. of sulphanilamide per 100 cc. Mild infections can be controlled by much smaller doses, for example, in pyelonephritis the urine can be cleared of pus on 10 gr. three times a day for a few days. Relapses are apt to occur. In some conditions sulphanilamide works better if combined with appropriate specific sera, e.g. in meningococcal meningitis.

Neoprontosil oral has been shown at the Mayo Clinic, Rochester, U.S.A., to have a dramatic effect on ulcerative colitis, but the work is too recent to estimate the permanence of the improvement.

Sulfapyridine or "M & B 693" or "Dagenan" promises to have a greater effect on mortality tables than any of the other compounds of sulphanilamide. The first English series of 100 cases of pneumococcal pneumonia treated by the drug had a mortality rate of 8%. The control series of alternate cases had 27% deaths. A recent carefully typed series of 100 American cases treated by sulfapyridine had 4% of deaths. It seems probable that the expensive, troublesome and occasionally dangerous serum therapy for pneumonia will soon be outmoded, or only used in combination with sulfapyridine in selected cases. The adult dose is 2 grams at once followed 1 gram 4 hourly till the patient improves, when the dosage can be reduced. Sulfapyridine works as well as sulphanilamide in streptococcal and meningococcal infections. It has helped a few cases of staphlococcal bacteremia. Experimentally it is effective against Friedlander and B. Welchii infections. The most troublesome toxic effect of sulfapyridine is nausea. This may be reduced by giving it as a powder in milk or apple sauce. A new sodium salt of sulfapyridine can be given in 2% solution by rectum. All the sulphanilamide compounds are unpleasant to take, and there is a risk of the patient developing haemolytic anaemia or agranulocytosis in the first week of treatment. Hence they should not be used in trivial conditions. Sulphates and eggs should be avoided with all forms of sulphanilamide to avoid risk of sulphaemoglobinaemia. The methaemoglobin cyanosis which frequently occurs can be overcome by administering 2 grains of methylene blue four hourly. This has the property of reconverting methaemoglobin to haemoglobin. Methylene blue is also useful in carbon monoxide poisoning.

Ergotamine Tartrate. ½ mg. subcutaneously has been shown to reduce to normal in 70% of cases the excessive pulsation of the temporal artery on the affected side in migraine, and stop the headache within an hour. It has no effect on the frequency of attacks. It should not be used oftener than once a week on older patients to avoid the risk of ergotism and gangrene. The first injection should be given in two doses in case of unpleasant reactions. Atropine 1/100 will counteract bad effects. Cases which do not respond to ergotamine may be relieved by the inhalation of 100% oxygen for an hour. Ergotamine will also arrest most attacks of supraventricular paroxysmal tachycardia.

Prostigmin was introduced as a very effective but expensive treatment for myasthenia gravis, but its widest field of usefulness is in paralytic ileus. The administration of 2 cc. (5 mg.) subcutaneously every 2 hours or oftener will often cause the count of peristaltic sounds to rise from 6 per minute to 20 per minute by the end of the day, when evacuation occurs. It is particularly useful as a prophylactic measure in doses of 1 cc. 4 hourly. This treatment can be combined with small doses of morphine to stimulate the gut and a nasal stomach tube or a Miller-Abbott tube.

Nitroglycerine has long replaced amyl nitrite as the drug of choice in angina pectoris. It is not so widely known that when administered before exertion it will prevent an attack. But its most recent use is in gall bladder colic. Experimentally it relaxes the sphincter of Oddi, while morphine causes spasm. Clinically it is effective in relieving over half the cases of gall bladder colic, particularly those not due to stone. It can be self-administered as often as desired. Nitroglycerine or amyl nitrite will relax spasms of the stomach or gut. This is sometimes of value to the radiologist trying to differentiate between an organic lesion and a spasm.

Protamine Insulin, which is slowly absorbed, has been widely publicized and does not require comment here. Most cases of diabetes can now be controlled by one daily injection. Newbergh has recently demonstrated that 90% of 183 obese diabetics could lead an insulin-free life with 300

* An address delivered to The Winnipeg Medical Society March 17, 1939.

gms. of carbohydrate daily, after reducing to a normal weight. The previous diabetic sugar tolerance curve came down to normal. The theory advanced is that excessive fat in the liver interfered with the deposition of glycogen.

Alfalfa Concentrate 1 *gm. with Bile Salts* 2 *gm.* daily for 4 days seems to be a good method for preventing haemorrhage in jaundiced patients. The effectiveness of the treatment can be checked by the rise in the prothrombin clotting time.

Congo Red 10 cc. of 1% solution intravenously is a harmless and frequently efficient method for arresting haemorrhage from the stomach, the lung, the kidney, etc. Congo Red causes a rise in platelets and fibrinogen and a fall in the clotting time. The exact mechanism is unknown.

Vitamin B cures peripheral neuritis due to poor dietary intake, e.g. in alcoholism, the vomiting of pregnancy, pyloric stenosis, pellagra, etc. According to some investigators who measure the blood vitamin B by a method involving the growth of a mould, there is no diminution of blood vitamin B in infective polyneuritis or in subacute combined degeneration of the cord.

Dihydrotachysterol, a derivative of ergosterol, is an effective oral drug for raising the blood calcium. In 6 severe intractable cases of tetany due to accidental parathyroidectomy there was elevation of the blood calcium to 10 mg. by the administration of 1/3 cc. t.i.d. The calcium could be maintained at the normal level by 1/3 cc. daily. No tolerance developed.

Sucrose intravenously is much superior to glucose or hypertonic saline for reducing the intracranial pressure, as the action is prolonged for 20 hours and there is no rebound of the pressure to a higher point than the original level. It also causes a marked diuresis. The maximum dose is 500 cc. of 50% sucrose.

The Metrazol or Insulin Shock treatments of Dementia Praecox have been widely publicized as improving the recovery percentage, but this is an institutional treatment to be administered by experts and needs no further comment here.

Phenobarbital gr. I t.i.d. administered postoperatively to 60 cases, with 40 controls, caused a diminution in gas pains and coughs in the treated series, who were able to leave hospital an average of 4 days earlier than the controls. This seems a harmless method for saving the patient pain and reducing his hospital bill.

Mebarol when tested in 2 epileptic colonies reduced the total number of fits to one-third of the control level on phenobarbital. It is given in 50% greater dosage than phenobarbital. The change over from one drug to the other should occupy a week.

Dilantin, a non sedative anticonvulsant, has achieved widespread popularity in the treatment of epilepsy. Of 118 Grand Mal patients 58% had no fits for 2 months. Of 74 Petit Mal patients 35% had no fits for 2 months. The drug has to be stopped in 5% of cases because of purpura. Others develop swollen spongy gums. The dosage is 1½ gr. from 2 to 6 times daily. The change over from phenobarbital should be gradual enough to last a week.

Benzedrine is well known as the active principle of an inhaler for shrinking the nasal mucosa. The drug for oral use in doses of 5 to 20 mg. is of value in narcolepsy, depression, sea-sickness, Parkinsonism and hypotension. The domestic uses include the restoration to normal of the sleep-soggy Sunday snoozer, the acquisition of super alertness by the examinee, and the revival of the sufferer with an alcoholic hangover. Administration after 3 p.m. may cause insomnia, as the effect is prolonged.

Rectal Ether is a simple and effective treatment for Status Asthmaticus, when adrenalin has lost its power. Equal parts of ether and olive oil are given rectally, one ounce of the mixture for every 20 lbs. of body weight. The patient has a long and restful sleep with easy breathing, and on awakening is usually responsive to normal doses of adrenalin, if it is required.

Salt and Cortin with low potassium intake has revolutionized the palliative treatment of Addison's Disease. Transplanting slices of foetal adrenals to the rectus sheath of Addison patients has been reported to cause remissions lasting a year. The most recent work on this disease concerns a useful diagnostic test. The urinary chlorides are estimated after a salt-free diet for 3 days. They are diminished in control cases but are still very high in Addison's Disease. This test can only be done in hospital where cortin and intravenous saline are available, in case the low chloride diet causes a crisis.

Reversals in Treatment

Phlebitis has kept patients bedridden for weeks because of the fear of pulmonary emboli. But in a large series of fatal cases of pulmonary embolus only 4% had had previously recognized phlebitis, and in all these cases the embolus had come from the good leg. The present teaching is that an inflamed vein has a firmly anchored clot. It is possible for an extension clot above the inflammation to become detached, but it is more probable that a stagnation clot in the good leg due to rest in bed will cause an embolus. In 700 ambulant cases of superficial phlebitis treated by elastoplast bandaging from the foot upwards there were no emboli. The bandaging diminishes oedema by supporting the tissues and causing a faster blood flow in the veins. Leeches applied along the course of the inflamed vein are said to cause a rapid relief of pain, redness and temperature. In old deep phlebitis exercise should be begun gradually, and the vein may be tied if extension clot emboli are feared.

Haematemesis cases are now fed instead of starved since Meulengracht published a large series of cases with 1% mortality instead of the

usual 12%. Only 4% needed transfusion. On the old treatment he observed that patients rarely died of the first haemorrhage, but usually a week or two later with the second or third haemorrhage, after they had been weakened by starvation. Meulengracht fed his patients a sort of convalescent Sippy diet with purees, 5 meals a day, with alkalis and iron. If his patients developed further haemorrhages they were much better able to withstand them. This work has been widely confirmed.

Advances in Technical Methods

Lead IV F on the electrocardiogram has raised the accuracy of cardiograph diagnosis of coronary thrombosis from about 75% to over 90%. Quite a number of cases show characteristic changes only in the fourth lead.

The Bragg-Paul Pulsator has superseded the Iron Lung. An apparatus resembling an automobile inner tube in the form of a shirt fits over the thorax and is connected to an intermittant air pump. A number of patients can be connected to the pump, and all pulsate together. The cheapness of the apparatus and the ease of nursing such patients is obvious.

The Encephalograph is an apparatus for recording electrical variations in the brain. Alpha beta and delta waves are described. Characteristic patterns are found in cases of petit mal and schizophrenia. Brain tumors are located with surprising accuracy. When the encephalograph is better understood it may be as useful in the diagnosis of diseases of the brain as is the electrocardiograph in disease of the heart.

REFERENCES

Neoprontosil for Ulcerative Colitis. Pro. Mayo Clinic, 1938, Vol. 13, p. 561.

Sulfapyridine. J.A.M.A., 1939, Vol. 1, p. 518, 529, 539.

Methylene Blue for Methaemoglobinaemia. J. Clin. Investig., 1938, Nov., p. 699.

Ergotamine Tartrate in Migraine. Am. J. Med. Sc., 1934, Vol. 188, p. 257.

Prostigmine in Ileus. J.A.M.A., 1938, Vol. 1, p. 1165; B.M.J., 1937, Vol. 2, p. 581.

Prostigmine in Myasthenia Gravis. J.A.M.A., 1938, Vol. 1, p. 198.

Nitroglycerine for Gall Bladder Colic. Surg. Gyn. Obstet., Oct., 1936, p. 451; J.A.M.A., 1937, Vol. 1, p. 501.

Protamine Insulin. J.A.M.A., 1937, Vol. 2, p. 500.

Fat Diabetics. J.A.M.A., 1939, Vol. 1, p. 10.

Alfalfa Concentrate with Bile Salts. Pro. Mayo Clinic, Nov. 30, 1938, p. 756.

Congo Red for Haemorrhage. B.J.M., 1934, Vol. 2, p. 762; New Eng. J. Med., 1936, April, p. 782.

Dihydrotachysterol for Tetany. J.A.M.A., 1938, Vol. 2, p. 304.

Sucrose to Reduce C.S.F. Pressure. Am. J. Med. Sc., 1936, Oct., p. 510.

Post-operative Phenobarbital gr. I t.i.d. Yr. Bk. Ther., 1937, p. 346.

Mebarol or Prominal in Epilepsy. B.M.J., 1937, Vol. 2, p. 67.

Dilantin. J.A.M.A., 1938, Vol. 2, p. 1068.

Rectal Ether for Status Asthmaticus. Yr. Bk. Med., 1937, p. 162.

Urinary Chloride Test in Addison's. J.A.M.A., 1938, Vol. 2, p. 121.

Phlebitis. Am. Heart J., 1937, Oct., p. 428 and p. 475; Am. Heart J., 1937, Dec., p. 772.

Haematemesis. Lancet 1935, Vol. 2, p. 1220.

Bragg-Paul Pulsator. B.M.J., 1938, Vol. 1, p. 1206.

Electroencephalography. J. Nerv. & Mental Dis., 1938, May, p. 598; Am. J. Med. Sc., 1938, Dec., p. 882.

NICOTINIC ACID (P.P. FACTOR)
RIBOFLAVIN (B_2)
VITAMIN B_6
THIAMIN CHLORIDE (B_1)
FILTRATE FACTORS
VITAMIN B_4
FACTOR W

Vitamin B Complex Syrup

If the diet is deficient in Vitamin B_1 it is logical for the Physician to assume it is deficient in many of the other factors of the B Complex. In treating:

VOMITING IN PREGNANCY	POLYNEURITIS
CHRONIC CONSTIPATION	ANOREXIA

by prescribing Squibb Vitamin B Complex Syrup the Physician assures his patient adequate amounts of Vitamin B_1 and all the other recognized factors in the B Complex.

AVERAGE DOSE: 3– T.I.D. plain or mixed with milk, tomato juice or similar vehicle.

Supplied in 3, 6 and 12-oz. bottles and 10-lb. containers.

For literature and samples write:
Professional Service Department, 36 Caledonia Road, Toronto

E·R·SQUIBB & SONS OF CANADA, Ltd.
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Special Articles and Association Notes

The Manitoba Medical Association Review

Formerly the Bulletin of the Manitoba Medical Association

ESTABLISHED 1921

WINNIPEG, JULY, 1939

Published Monthly by the

MANITOBA MEDICAL ASSOCIATION

Editorial Office

102 MEDICAL ARTS BUILDING, WINNIPEG

Editor

C. W. MACCHARLES, M.D. (MAN.)

Advisory Editor

ROSS B. MITCHELL, B.A., M.D., C.M. (MAN.), F.R.C.P.(C.)

Business Manager

J. GORDON WHITLEY

Annual Subscription - $2.00

Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association

Annual Meeting

The plans for the annual meeting of the Manitoba Medical Association September 11th, 12th and 13th are now well advanced.

The Canadian Medical Association have arranged for the following visiting speakers:

Frank S. Patch, B.A., M.C., C.M., F.R.C.S. (C.), Professor of Surgery, McGill University, Montreal, and President-Elect of the Canadian Medical Association.

H. B. Cushing, B.A., M.D., C.M., Emeritus Professor of Paediatrics, McGill University, Montreal.

Roscoe R. Graham, M.B., F.R.C.S. (C.), Assistant Professor of Surgery, University of Toronto.

W. G. Cosbie, M.D., M.B., F.R.C.S. (C.), Senior Demonstrator in Obstetrics and Gynaecology, University of Toronto.

T. C. Routley, M.D., LL.D., F.R.C.P. (C.), General Secretary, Canadian Medical Association.

In addition, there is to be an exchange of speakers with the British Columbia Medical Association. It is hoped that Dr. C. H. Vrooman will be able to attend. Dr. Vrooman is a physician who has specialized in the treatment of chest conditions, and has made a detailed study of the silicosis problem.

Clinics will be arranged at some of the Winnipeg hospitals, and it is hoped this year to include on the programme some medical motion pictures.

Minutes of Executive Meeting

Summary of minutes of a meeting of the Executive Committee of the Manitoba Medical Association held in the Medical Arts Club on Tuesday, May 23rd, 1939.

Present.

Officers and members of Executive:

Dr. W. S. Peters, Chairman
Dr. O. C. Trainor
Dr. Geo. Clingan
Dr. W. E. Campbell
Dr. C. B. Stewart
Dr. Geo. Brock
Dr. C. E. Corrigan
Dr. O. J. Day
Dr. E. J. Skafel
Dr. S. G. Herbert
Dr. C. W. MacCharles.

Chairman, Committee on Sociology:

Dr. E. S. Moorhead.

Reading of Minutes

Following dinner, the President called the meeting to order at 7.30 p.m. and requested that the minutes of the last Executive meeting, January 17th, 1939, and also minutes of a special meeting held on May 2nd, 1939, be read.

It was moved by Dr. Geo. Glingan, seconded by Dr. C. B. Stewart: THAT as copies of these minutes had been given to the members that they be taken as read. —Carried.

Business Arising Out of the Minutes

Health Insurance.

Dr. Moorhead stated that a report had been received from Dr. Wilson, but there has not been time for the Committee on Sociology to study it.

Contract Practice.

Dr. Moorhead reported that a certain amount of information had been obtained but that it was not of much importance, and therefore the Committee on Sociology had nothing to report at this stage.

Voluntary Health Insurance.

Dr. Moorhead reported that his Committee had not had time to study this question.

Lodge Practice.

Dr. Moorhead reported that the Committee on Sociology continued their investigation as to lodge practice, as suggested in the original communication from the Committee on Economics of the Canadian Medical Association. A questionnaire had been sent out to 385 doctors in Greater Winnipeg, and 225 doctors, that is 59%, had replied. The replies to the questionnaire had then been summarized by two members of the Committee on Sociology, and their opinions were incorporated in Dr. Moorhead's report.

It was moved by Dr. E. S. Moorhead, seconded by Dr. W. E. Campbell: THAT this report be accepted. —Carried.

Salaries to State Medical Officials— Report from Committee on Sociology.

At a meeting of the Sociology Committee held on May 17th, Dr. Moorhead submitted a list of the salaries paid to state medical officials and read a draft of a report for submission to the Executive Committee of the Manitoba Medical Association. The Sociology

Committee passed a motion that the complete report be adopted and submitted to the Executive Committee.

The Chairman of the Committee on Sociology read the following report to the Executive:

"To the President and Executive Committee of the Manitoba Medical Association.

"The Committee on Sociology presents herewith its report on the salaries of whole-time employees of the state, the latter term including all departments of the provincial government, of municipalities, urban and rural, also some federal departments. Not all employees replied to the circular; where it appeared to be important, salaries in these cases were obtained from public reports. It was felt that the picture would be complete if whole-time employees of hospitals and private sanatoria were invited to report. Circulars were sent to all superintendents, pathologists, and other full time employees of general hospitals or private sanatoria. Two pathologists alone replied.

"Many officers took the trouble, for which acknowledgement is made, to give the Committee full details of the conditions of service, etc., and from these replies a resume has been made.

"In the case of some appointments, there is a further subsidiary appointment which carries a salary; in a few cases this is substantial but in the larger number the amount is small. It should be noted that municipal doctors can and do increase considerably their incomes by such additions as major surgery, life insurance, periodic health examinations, workmen's compensation cases, private patients coming from neighboring areas, and the provision of drugs. Extras for use of car or travelling expenses have not been included in salaried appointments. Note is made of these cases where subsistence is included. This term covers a separate residence within the grounds of the institution and the services of a maid, or suites of varying sizes in the main buildings; it also includes rations for the officer and his family, laundry, fuel and light. It is acknowledged that all these are computed at a very moderate rate, which is of assistance in submitting income tax returns. Hours of duty vary widely; even when specifically laid down a state officer may be required for emergencies any time during the twenty-four hours. Holiday allowance appears to be reasonable.

"Two specific complaints recur: (1) With very few exceptions no arrangement is made for pensions. (A provincial pension scheme was established as at May 1st, 1939). (2) There does not appear to be any general policy of an annual salary increase to a maximum for specific grades and classifications. (Establishment of minimum and maximum salaries for all positions together with annual increase, is to be completed by the provincial government during ensuing year).

"Many writers expressed their appreciation of the efforts of the Committee on Sociology on their behalf and hoped that publication of terms of service might be of benefit.

"The Committee on Sociology not having been asked to make recommendations attaches the salary schedule and concludes its report."

The salary schedule was submitted to the Executive.

It was pointed out that in Dr. Routley's original letter of November 18th, 1939, that question number three referring to salaries to state medical officials, read as follows:

"In event of answering numbers 1 and 2 in the affirmative, what suggestions have you to offer as to how this study should proceed; and have you any suggestions to offer as to classifications and amounts of salary which should be paid to each? (In replying, the Executive would appreciate your views on the whole question of classification and the selection of candidates for the various posts.)"

It was moved by Dr. E. S. Moorhead, seconded by Dr. C. E. Corrigan: THAT an answer to question three in Dr. Routley's letter of November 18th, 1938, be deferred until after our report and that of the other provinces have been submitted to the Canadian Medical Association Executive, and they have made a preliminary study. —Carried.

Rural Relief Cases.

The Chairman of the Committee on Sociology read the summary which he had prepared from the replies of rural practitioners to the questionnaire. This had been considered by the Committee on Sociology on May 17th. The chairman stated that the porportion of replies returned by rural practitioners was low—only 17% and the committee had been rather disappointed that more practitioners had not taken the trouble to reply. By contrast, when a questionnaire had been sent out to practitioners in Greater Winnipeg asking for information with regard to lodge practice, 59% had replied.

Among the 17% of rural practitioners who replied, about one half appeared to be satisfied with the arrangements for the care of relief case and the other half were dissatisfied.

(Note.—Some of the replies which repeat suggestions contained in preceding ones have been deleted from the printed minutes).

---

(1) TOWN AND R.M.—Doctor approached his Council five years ago, and they finally paid half rates for emergencies. Office calls and minor cases free. Neighbor R.M. cannot or will not pay. Maternity work not regarded as emergencies. Methods of reasoning, education and persuasion better than force. Suggest clause in Municipal Act showing responsibility of Municipal Council for health.

(2) VILLAGE AND PARTS OF 4 R.Ms.—a, b, c, d. —Village (Doctor's residence). Never paid and won't pay. Has not appeared before them. (a) Pays him as M.O.H. $250.00 and he usually throws in indigent care; (b) gives a retainer of $20.00 a year and mileage 75c one way. Have at times honored accounts; (c) and (d) never pay.

(3) TOWN AND 3 R.Ms.—Two doctors presented case to Town Council and receive satisfactory treatment. (a) Not so good—no authority, no pay. (b) Satisfactory. (c) No good. If doctors stick together they can get what they want.

(4) CITY.—Sees quite an improvement in relations between council and doctor in last five years. At first there was obstinate opposition and doctors not unanimous. Started a campaign of publicity. Council now pays $1,500 per annum. It has been demonstrated that by continual effort in raising a subject never before active, success may be accomplished. Suggests that other districts organize for constant agitation to bring medical subjects before public and press, and by deputations.

(5) TOWN.—Council pays for first visit and any others that M.O.H. sanctions. Sets aside a sum to meet this; also $10.00 for maternity cases in hospital, $15.00 outside.

(6) TOWN AND 6 R.Ms.—Town doctor's own residence. Pays nothing. R.M. "a" and "b" pay $50.00 for major operations if authorized, $15.00 maternity in hospital, some T & A $15.00. R.Ms. (c.d.e.f.) are difficult. Arrangements should be provincial in scope.

(7) 2 R.Ms.—Each pay $50.00 per month as M.O.H. Custom to regard it as including indigent care. Transportation sometimes exceeds salary. Believes one of the councils could not increase the subsidy because expenditures are controlled by Utilities Board in Winnipeg. Suggests organized effort, since the problem

cannot be handled by local doctor. Not likely to have municipal doctor in that area.

(8) R.M.—Bad. Reeve at meeting said he would sooner pay hospital fees of $1.50 than doctor. Practices in two other municipalities; treated much better —maternity cases $15.00. Any other system preferable to present one.

(9) R.M.—Municipality pays $500.00 a year. He sends $25.00 often to two doctors who operate on his cases. A municipal doctor scheme would not work here unless a new area was formed.

(10) R.M.—Fairly satisfactory. Pay $15.00 for maternity cases and authorize country calls. 25c a mile each way and $2.00 for examination. No surgical fees. Objects to disclosing nature of illness to councillors.

(11) R.M.—"I am a municipally paid doctor, by contract bound to provide medical services to all residents and their dependents of this municipality. In every case these services shall be free to the individual concerned with the exception of any actual cost that I may have incurred (the cost price of dressings, adhesive, x-ray plates, etc). Where hospitalization is necessary, I am expected to provide my services to the full extent of my capabilities. For this I may charge a fee which will represent 75% of the usual fee, or of what I would charge an outsider. The R.M. assumes no responsibility in the payment and collection of these fees."

(12) "To date this municipality has been very fair to me in the treatment of non-paying patients. You will please note, that I do not use the word indigent. However, this year there has been a distinct hardening in the attitude of my Council noted. This, in my opinion, is due entirely to the following causes. I was told quite frankly, that neighboring municipalities are sending their patients into Virden, Souris, Brandon and Winnipeg hospitals, and getting free medical service, the only cost to the municipality being $1.50 a day. It is my considered opinion, that the absolute refusal of medical men in hospital towns to do free work for non-resident patients, would go a long way in the solving of this problem. My experience indicates that doctors in hospital centres will not hesitate to certify as emergent, and send patients to hospital for trivial things. They figure (and in most cases rightly) that the local Health Officer will not have the nerve to say anything. I have my own opinion as to why they do this, but it does not really bear directly on the present question.

"All the municipal councils are learning about this 'racket,' and unless it can be stopped all rural men will be in the same boat—doing the work for nothing. The Winnipeg men are bad offenders in this respect. Why should they take it upon themselves to do rural work gratis? They are doing both themselves and us a very serious injustice. Why do local health officers send patients to your public wards? It is because our hand is forced. The municipal councils understand the situation, and if consent is not given they are sent any way. They can always get admitted to the public ward. The clause in the Public Health Act requiring the signature of the local health officer, has been made a farce by the doctors themselves. The public have come to realize this also.

"Clear our own yard, and then it will be soon enough to approach the Union of Municipalities."

(13) TOWN AND R.M.—Crisis a few years ago. Two municipal councils offered to pay 50% when authorized; other 50% to be collected by doctor. Not acceptable. Now refers indigents to council; if latter authorize service it is paid for. Only a few dollars from R.M. and none from town. Recently things have been evened up by payment for vaccination and toxoid. Councillors ignore duties to human beings and doctors lack back bone.

(14) M.O.H. for part of (a) municipality and deputy M.O.H. for (b) municipality. Doctor does not receive retaining fee but is paid on mileage basis for health work. (a) Pays 50% for a minimum of attendance (b) rarely pays for anything. I have to battle over each case and try to show that service at home will be cheaper than hospitalization at $1.50 a day. Council do not object to hospitalization, as hospitals need the money. Rural doctors in western Manitoba criticize Brandon city doctors. If they would refuse free treatment to municipal cases our hands would be strengthened.

I think M.M.A. should press for standard agreement with municipal councils to assure some payment for relief cases. I do not fear municipal doctor here. Most councils would sooner pay nominal fees than embark on municipal doctor scheme.

(15) TOWN AND R.M.—M.O.H. for town. Reasonably well treated. $400.00 as M.O.H. salary covers care of indigents and relief cases, but no emergency surgery. Few on relief and the usual proportion of indigents. Neighboring R.M. has always refused to do anything. Appreciate efforts of Committee on Sociology but does not feel that the matter should be pursued in his community.

(16) "I might say that it is high time that the rural medical men got together and set some fair standard of remuneration for their services to indigents and those requiring municipal aid. If the Association does not set a standard fee and standard requirements, we have little to guide us and the individual medical man cannot justify his charges. A few years ago I went to the Council and asked to be reimbursed for a trip in the country to a well known indigent—I only charged 50% of the regular fee, 50c a mile. After I had left the Council chambers the Reeve was reported to have said that he couldn't see why a damned M.D. should get 50c a mile when he only got 10c a mile as Reeve for inspecting a bridge. The other Councillors to avoid any argument decided that as I had not got their permission before making the trip I should get nothing. I think that this requirement of getting the consent of the Reeve before attending an indigent is pretty much a general rule throughout the province, and in practise it works out rather badly for the doctor, especially when the Reeve has no 'phone and the call is in the night. Your suggestion that many doctors are afraid to disturb the status quo shows clearly that these doctors are under the thumb of their councils—throughout the province there is no standard of equity. Each doctor has to depend on himself—if he has a reasonable Reeve the matter is amicably decided and the doctor receives fair remuneration—but if the Reeve is a tight-wad or antagonistic the doctor's only recourse is to attend all cases and hope that he will receive his reward elsewhere. The fact that various doctors have different arrangements with their local councils shows that the country doctor is acting as an individual and not as a member of an association. Uniformity of action is the only fair basis for any agreement between the doctors and their councils.

"If the urban doctors considered it a vital necessity to band together to secure proper payment for services given to indigents, then it should be accepted that the country doctor should receive the backing of the whole medical profession in his request for proper recognition by his council. The fact that he is often afraid to press his claims should not invalidate the principle which his urban confrere considered important.

"Formerly I received $50.00 a year for looking after all the health work in the west half of the municipality, this included all expenses, all quarantining, etc., and on very rare occasions I received payment for a confinement case, $15.00 for a country case and $10.00 for a town case. I received $5.00 for a 10-mile trip and paid my livery in winter $4.00, but these payments were very rare and usually after much per-

suasion. Certainly I did not consider I received a fair deal, but what was my recourse—of what benefit was it to belong to a medical association whose city members were reimbursed and whose country members were left to fight their own battles. Possibly you were right in saying that we were to blame (partly) in not being able to secure proper recognition from the councils at the time the doctors in Winnipeg secured payment for their services to indigents. However, many of the larger towns in the province where there were several doctors, failed also. The individual doctor is up against a hopeless task, unless he is a super salesman, and unless the medical association stands solidly behind him. The fact that today the city doctor receives payment for his services and the country doctor receives little or nothing, tends to divide the association and shows group preference."

(18) R.M.—Relations quite satisfactory. Not many indigents there. If authorized bills are paid.

(22) 2 R.Ms.—M.O.H. of northern part. (a) Retaining fee $50.00 per year. Any authorized work is paid for, relief or otherwise. (b) All authorized work paid for. All difficulties easily straightened out.

(23) SEVERAL R.Ms.—(a) Has a medical fee system which is quite fair. (b) Treats M.O.H. fairly and gives consideration to payment for indigents. (c) Town—not keen on giving help; take the attitude that a doctor cannot refuse services. (d) Non paying, non co-operative class, rarely pay. (e) In a class by itself. Demand services and flatly refuse to pay; anxious for a municipal service. M.O.H. for a portion of this municipality, and receives payment for 25% of services. No payment for indigent or relief cases. Doctor says that this municipality is bankrupt and expects some one else to pay for municipal doctor.

(24) Rural practitioner gets little help from M.M.A., therefore has never joined. Glad to hear of action. (1) He leaves drugs, etc., at house for which he receives nothing. (2) Council maps out municipal doctor area and makes it too large. (3) Suggests standard area, ditto fees and payment for drugs left.

(26) R.M.—Unsatisfactory. Reeve says "no money for medical aid." For confinements a small remuneration by threatening hospitalization with railway fares and fees. When called in capacity of M.O.H. bill is promptly paid. Council decline to immunize the school children.

(27) VILLAGE AND R.M.—R.M. give retaining fee of $40.00, and 50c a mile for those on relief; nothing for surgery. Village $50.00 only, but are considering a grant for care of relief. Vaccination (smallpox) and toxoid 50c each. A municipal system which does not supply surgery is a cheat, as only half expenses are met.

(28) R.M.—"The Municipal Council does not, and has never in the past paid for medical services to indigent patients other than those on relief.

"The only money I receive from the municipality is an annual retainer fee of $80.00 and mileage of 75c per double mile in case of infectious diseases, including two trips made in the capacity of a Health Officer.

"In case of services in unorganized territory, the present regulations are as follows: When a doctor gets a call from a patient in unorganized territory, he is directed to communicate with the Provincial Board of Health and get a permission for such visit. If such permission is granted then the doctor will receive payment; but if the doctor answers the call on his own initiative then payment will as likely be refused."

(29) TOWN, PART OF R.M. (a) ALL OF R.M. (b).—Treatment has been fairly generous with regard to indigent care. All M.O.H. work paid for by visit or mileage. Town—no relief for indigents, just straight charity. Retaining fee raised from $30.00 to $100.00 to cover indigents. R.M. (a) pays ⅔ of Winnipeg relief schedule. R.M. (b) honors all indigent accounts in full, and do not quibble as to whether they are on relief or not, as long as they are indigent.

"Whatever I have been able to secure from these councils has been partly due to your own excellent work.

"In a general way I believe medical relief costs should be removed from local control. A provincial board could pay all relief medical accounts, through a municipal levy. Equality of treatment would then be possible for all practitioners."

(32) R.M.—"Our Council has always treated me pretty well, although they pay only for relief patients. The biggest problem is to collect from farmers that are not on relief. But the rate of payment is rather low—$10.00 for a confinement, for instance. However it is take that or nothing. I think the Council is doing quite well considering the times and that they consider themselves responsible only for people on relief."

The Chairman of the Committee on Sociology then read the following minutes of the meeting of the Committee on Sociology held on May 17th, 1939, with the resolution which had been adopted.

The Chairman discussed the information which he had received from practitioners in rural areas with regard to relief cases, and pointed out that several of the men had objected to the alleged practice of Winnipeg Hospitals admitting to public wards patients whom the rural doctors considered should be able to pay for both medical services and hospital accommodation. He had asked Dr. Stephens, Superintendent of the Winnipeg General Hospital, and the Business Manager of the St. Boniface Hospital, both members of the Manitoba Hospital Association, to give their opinions.

Dr. Stephens discussed the report which he had sent to Dr. Moorhead, a summary of which follows.

Dr. Stephens pointed out that one of the chief difficulties is that the Rural Health Officers and Practicing Doctors are not familiar with the Hospital Act and the conditions under which a patient, chargeable to a municipality, may be admitted to hospital. He also pointed out that when the Hospital Act was revised by the Legislature, the Manitoba Medical Association did not have a representative present with a watching brief during the proceedings.

The chief complaints from Reeves and Municipal Councils were that patients from rural areas were kept too long in hospital and that patients were admitted who did not require hospital treatment. The former complaint has been demonstrated not to be valid with regard to metropolitan hospitals. The latter has arisen at times because of the objection of local doctors whose patients had ignored their advice and gone to a City, for example, the Maternity case which had been the great bone of contention. When the patient leaves home the case is not urgent, but when the patient arrives at the Hospital there is no time for any delay. Similarly other conditions in dispute that he recalled to mind are old standing hernias, threatening obstructions or actually obstructed; previously balanced diabetics, showing acidosis or even beginning coma; inoperable cancer for palliative treatment.

He pointed out that Municipalities rarely pay fees for medical services in metropolitan hospitals, although according to statements made by rural practitioners fees were often paid for medical services in the local hospitals. In Saskatchewan and for Saskatchewan patients sent to Manitoba a professional fee is frequently paid by the Municipality.

A patient is frequently sent to the metropolitan hospital, requiring elaborate investigation and or expensive treatment, e.g., cancer, brain tumours, etc.

Further, these cases have to be hospitalized over a prolonged period. Obviously the statutory grant is insufficient to meet the cost, and municipal councils persistently take protection from the Act and refuse to pay for these extra services.

After reading the replies from rural practitioners Dr. Stephens made the following comments:

1. The confidential character of illness: according to the Act the hospital is required to state the reason for admission for unauthorized patients, which reason may be in some cases considered a breach of confidence. The Act requires that this documental form be sent to the Secretary of the Municipality as well as the Health Officer.

2. I agree with the doctor who says we should not use the word "indigent" though it is frequently used throughout the text. The term is not used officially in Manitoba phraseology insofar as hospital patients are concerned, though some members of the Department of Health by frequent reference to it are gradually bringing it into general use. I hope it may be kept out of Manitoba legislation.

3. The inclusion of the word "emergent" or "emergency" is erroneous. There is nothing in the Act demanding that a case be an emergency. Certificate is that "it is unwise to delay."

Dr. Stephens' suggestions with regard to improving the situation were as follows:

1. That sections of the Hospital Act should be published from time to time in the Manitoba Medical "Review" for the information of medical men.

2. That articles on sections of the Hospital Act might be published in the Western Municipal News and the Country Guide for the information of officers of municipalities.

3. That formal letters to Reeves or Secretaries might be of some value as they were usually read to the Council.

4. That personal visits by representatives from the hospitals could be made to rural councils at which time problems could be discussed.

The following letter from the business manager of St. Boniface Hospital to the Chairman of the Committee on Sociology was then read:

"I have carefully perused your circular letter of March 6th last, directed to the Manitoba Practitioners outside of Greater Winnipeg area together with extracts from various opinions expressed by a number of such practitioners, and I am glad to respond to your wish in giving you my opinion as a layman who has been connected with hospital work from a business standpoint for the last six years and having had previously some 20 years experience in municipal work.

"I would state at the outset that the main difficulty that I see in the way of your very reasonable objective is obviously the apparent lack of unity on the part of those most vitally interested in the matter, and needless to say that this situation must of necessity be the first lacune to correct.

"It is well known that the bugbear of a great many Municipal Councils is Hospital and Medical Accounts, but depending in a very large measure on the leader's sentiments or dispositions on these questions.

"My experience is that in some cases at least, the Medical Man is to some extent responsible for the attitude taken by such Councils, by not taking the trouble or the proper means to obtain favorable reaction through personal contact in or outside of Council Meetings; some of them do not seem to care or perhaps take the view that it would be below their dignity.

"A reeve mentioned 'That he would sooner pay hospital fees of $1.50 than the Doctor.' I have myself heard that expression on different occasions on the part of members of certain councils. Unfortunately for the hospitals who are endeavoring to impress upon them that the statutory rates for public ward patients are not adequate, and that the hospitals are justly entitled, if not clearly defined in as many words in the statutes, to collect from the patients for the extra services over and above the obligation of the Municipality. We all feel that there are some patients who would be financially able to pay their own bills to the hospitals as well as the attending Doctors and would do so if, for political reasons, they had not been advised by either the Reeve, the individual Councillors or even the Secretary-Treasurer to have their bills sent to the Municipality so as to avoid payment for extra services. There is there an anomaly which is difficult of correction but not unsurmountable.

"With reference to the admission of public ward patients with or without the proper authority from the Medical Health Officer or the Municipality, this has been and is still a point of contention judging from our experience here, and I believe that this also applies to the other hospitals in Greater Winnipeg, but there are relatively very few cases where hospitalization is not warranted. It is generally conceded that hospitals cannot very well refuse admission of patients coming from outside of Greater Winnipeg until at least the provisional diagnosis has been determined. We generally phone the proper officers of the Municipality in such cases with satisfactory results. We also find that in some cases, mostly maternity, for some reason or other, the expectant mother claims that she has had some unpleasant experience with either the Health Officer or the Local Doctor which she offers as an excuse for not having applied to the Health Officer for authority for her hospitalization, and these patients generally come to the hospital at the last moment which naturally leaves no other alternative than to admit them. I might say, however, that this situation is better understood by all concerned.

"In any event, when the officials of the hospital feel that public ward patients are not strictly speaking indigents, endeavors and sometimes reasonable pressure are exercised to have them choose their own physicians and pay for both the hospital and the physician. I venture to say that the whole situation as to the relations between the Municipalities, the Medical Officers and the Hospitals is gradually improving, it being fully recognized that mutual co-operation in the matter is essential.

"If I am permitted to offer a suggestion, the whole rural problem could be reasonably solved by a systematic campaign such as you have so splendidly conducted in Greater Winnipeg, and the most effective way of doing so in rural districts, in my opinion, is by personal contact with each individual council throughout the Province. The task would not be as difficult as one would be inclined to believe at first blush; for instance the Province could be divided in four districts for the purpose, and suitable representatives of your Association from Winnipeg and other large centres delegated to visit the Councils in each district and conduct a well prepared educational campaign. I dare say that with a proper itinerary, all the rural councils could be covered over a period of say some six months. I bear in mind the fact the Councils meet practically all during the first week of the month, but as they generally sit all day, your delegates by motoring could meet on the same day some three, four and even five councils.

"I am speaking from my own actual experience in connection with my work for this Hospital, and have no hesitation in saying that in my own modest way, I have been successful in settling disputes, misunderstandings and long past due accounts simply through round table conversations with members in Councils, applying myself to show the hospital side of the question. I have without any exceptions been received

with courtesy and attention, even at places where I was expecting anything but that. They generally show that they appreciate the fact that one takes the trouble to drive miles to meet them and state his case viva-voce.

"I only regret that my office occupations do not allow me to extend my activities in that particular sphere as much as I would like to, as I am firmly convinced that this system is the most effective one. I do not forget that it cannot be done without some sacrifice both in time and money, but it is generally amply justified.

"The campaign could then be followed up through the Union of the Manitoba Municipalities for the purpose of obtaining some reasonable legislation which would ensure, once for all, the principle that the medical men the same as the Hospitals are entitled to receive adequate remuneration for services rendered to indigent patients. The movement would also, in my estimation, go a long way towards obtaining that both the Provincial and Federal Governments deal with these public services in the same manner as they do for direct relief and that is on a tripartite basis, as to the best of my knowledge, Cities, Towns and Surburban Municipalities have been practically the only ones so far to earnestly press the Governments in that respect so that if the Rural Muicipalities would join in the movement, no doubt that it would hasten the Governments to respond favorably.

"Trusting that this opinion, which I give in all sincerity may be of some assistance to you in your worthy but difficult task."

Dr. Mitchell thought that the difficulties between city physicians and metropolitan hospitals on one hand and rural municipal councils on the other, might best be solved by personal discussions. If representatives of metropolitan hospitals and members of the Executive of the Manitoba Medical Association could state their case before the district meetings of the Union of Manitoba Municipalities much might be accomplished. The presidents or officials of the Union might also be invited to sit in at meetings of the Executive Committee of the Manitoba Medical Association.

Dr. Gordon supported this suggestion.

Dr. Campbell pointed out that he had suggested at the Executive meeting that it might be advisable to have a standard form for admission to hospitals by which any patient who was admitted to the public ward was required to sign a certificate that he was unable to pay the full costs of hospital accommodation and medical service.

Dr. Stephens doubted if it would be possible to secure such legislation. If such were secured it would further hamper the admission of patients, a process which already penalizes the hospital and is a constant source of annoyance to the practising physician.

Dr. Campbell pointed out that when this question was discussed at the Executive meeting, the secretary was instructed to ask for the opinion of the Deputy Minister of Health and it could then be discussed at the next Executive meeting.

Dr. Moorhead then dealt with the general problem of rural relief cases and recounted his experience at Carman. One doctor had written in to ask if the Chairman of the Committee on Sociology would interview the Carman Municipal Council with regard to making provision for the care of indigents. After this request had been signed by all the doctors in the town, Dr. Moorhead interviewed the Municipal Council and succeeded in having them agree to making some reasonable arrangement with the doctors.

Dr. Moorhead pointed out that there was no difficulty encountered in these negotiations, and that the Council appeared to be quite reasonable.

Dr. Moorhead then discussed the report that should be submitted to the Executive Committee of the Manitoba Medical Association with regard to rural relief cases.

It was moved by Dr. J. A. Gunn, seconded by Dr. Athol Gordon: THAT the Committee on Sociology recommend to the Executive Committee of the Manitoba Medical Association that the best solution of the difficulties with regard to the care of indigent cases in rural areas, would be that the Executive offer to the practitioners concerned, the assistance of a representative of the Manitoba Medical Association who might be sent to help the local medical men negotiate with their Councils, provided that in each case the request for assistance should come from all the doctors in the area concerned. —Carried.

It was moved by Dr. E. S. Moorhead, seconded by Dr. E. J. Skafel: THAT this report of the Committee on Sociology with regard to rural relief cases and the resolution be adopted. —Carried.

Discussion followed with regard to the publication of this report, and it was moved by Dr. O. C. Trainor, seconded by Dr. E. J. Skafel: THAT this report of the Committee on Sociology adopted by the Executive with regard to rural relief cases, be published in the "Review" and a copy be sent to the secretary of each district society with a covering letter. —Carried.

Annual Meeting.

Dr. Corrigan, Chairman of the Programme Committee, read the list of visiting speakers from Toronto and Montreal, and also reported that arrangements were going forward for exchange of one clinician with British Columbia. It would probably be possible to include some medical motion pictures in the programme.

It was moved by Dr. C. E. Corrigan, seconded by Dr. Geo. Brock: THAT this report be accepted. —Carried.

Representation on Workmen's Compensation Medical Appeal Board.

The following report was submitted by Dr. Corrigan:

"As instructed at the last Executive meeting, the treasurer and secretary interviewed Dr. Fraser of the Workmen's Compensation Board on May 19th and discussed the question of the best arrangement for the Medical Appeal Board appointments.

"Dr. Fraser confirmed our information to the effect that the Manitoba Medical Association has never made any subsequent appointments to the Medical Appeal Board, or suggested any further names for Chairman or Vice-Chairman since the original communication dated February 20th, 1934.

"Dr. Fraser stated that the relation between the Board and the profession has always been amicable as far as he was aware during the past number of years.

"The treasurer and the secretary of the Manitoba Medical Association were also instructed to draw up a tentative list of names for a panel for the Medical Appeal Board of the Workmen's Compensation Board.

"It was moved by Dr. C. E. Corrigan, seconded by Dr. O. C. Trainor: THAT this report be accepted. —Carried.

Cancer Relief and Research Institute.

The secretary advised he had written as instructed to Dr. P. Macdonald for a list of the names of the members of the Board of the Cancer Relief and Research Institute, and had received a reply advising Dr. Macdonald was out of town. This matter was therefore left in abeyance until the next Executive meeting.

Dr. Strong's Letter.

The secretary reported that as instructed he had written to Dr. Strong on two occasions asking him

for his opinion on the Committee's report, but he had as yet received no reply.

It was moved by Dr. W. E. Campbell, seconded by Dr. O. C. Trainor: THAT the secretary write to Dr. Strong once more and that if no reply is received the report be considered at the next Executive meeting. —Carried.

Broadcasting.

The secretary reported that no report had been received from the Chairman of the Radio Committee.

Relief Cases in Unorganized Territory.

The secretary reported that as instructed at the last Executive meeting he had commenced discussion of this problem with the Deputy Minister of Health, but that it would be necessary to arrange another interview in order to finish discussion. It was decided to leave this matter over until the next Executive meeting.

Record of Presidency.

The secretary stated that no report had been received as yet from the Special Committee appointed to consider this problem.

Letter from Dr. Fraser Re. Biographic Data.

The secretary reported on a letter received from Dr. Fraser asking if it would not be possible to obtain authentic biographic data on all the practitioners in the province. He stated that he had also interviewed Dr. Fraser at Brandon. The secretary advised that he thought this would be a very expensive procedure and of little tangible value.

It was moved by Dr. O. C. Trainor, seconded by Dr. S. G. Herbert: THAT the secretary write to Dr. Fraser and advise him that the procedure suggested in his letter would be too expensive. —Carried.

Letter from Dr. Bardal.

The secretary read the minutes of the special meeting of the Executive on May 2nd with regard to a letter from Dr. Bardal. He advised that, as instructed, he had written to Dr. Bardal under date of May 12th requesting further particulars, but as yet no reply had been received. The letter was left over until the next meeting.

Delegates to Canadian Medical Association Council.

The secretary advised that a telegram had been received from Dr. Routley stating that names of the representatives from Manitoba were urgently needed, and that after consultation with Drs. Campbell and Corrigan he had written under date of May 9th giving the names.

It was moved by Dr. O. C. Trainor, seconded by Dr. C. B. Stewart: THAT these be our official delegates to the meeting of Council of the Canadian Medical Association at Montreal. —Carried.

Dr. Walton Re. Pollen Survey.

The secretary reviewed the relevant portion of the minutes of the special meeting of the Executive on May 2nd, and reported that he had received a letter from the Medical Research Committee stating that they approved of this survey and were writing to the Department of Health to this effect.

Dr. Trainor suggested that this survey should have the support of this Association, and that a letter be sent to the Department of Health advising that this work has the approval of the Manitoba Medical Executive.

It was moved by Dr. E. J. Skafel, seconded by Dr. O. C. Trainor: THAT a letter to this effect be sent to the Department of Health. —Carried.

Letter from Dr. N. G. Trimble.

The secretary read letters received from Dr. Trimble and the relevant excerpts from the minutes of the special meeting of the Executive on May 2nd.

Dr. Campbell suggested that the representation on the Executive might be arranged for the northern part of Manitoba by nominating a member at large from this district.

It was moved by Dr. C. B. Stewart, seconded by Dr. E. J. Skafel: THAT this correspondence be filed and that a memorandum be made of Dr. Campbell's suggestion for the information of the Nominating Committee at the annual meeting. —Carried.

Inter-State Post-Graduate Medical Association.

The secretary read the reply to his letter to this Association in which they stated that they would consider the question of a meeting in Winnipeg and communicate further with the Manitoba Medical Association. It was decided to file the correspondence in the meantime.

New Business

Letter from Canadian Society of Radiologists Re. Radiological Services in Group Hospitalization Plans.

The secretary read a letter received from the above association, and reported that as instructed he had written to the radiologists in Winnipeg and was advised that further information would not be available until after a meeting of the radiologists to be held in June. The correspondence was, therefore, ordered filed.

Letter from Manitoba Hospital Association.

Letter from the Manitoba Hospital Association under date of May 20th was read by the secretary, extending an invitation to attend the one-day convention in joint session with the Manitoba Association of Registered Nurses to be held on June 13th at the Royal Alexandra Hotel.

It was moved by Dr. O. C. Trainor, seconded by Dr. E. J. Skafel: THAT the Vice-President and Secretary be appointed to attend this meeting. —Carried.

Abridged Report of Committee on Economics of Canadian Medical Association.

An abridged form of a special report to the Executive Committee of the Canadian Medical Association submitted by the Committee on Economics of the Canadian Medical Association on March 13th, 1939, was made available to the meeting but not read. As a limited number of these reports were received from the Canadian Medical Association, it was decided that a copy be sent to each member of the Committee on Sociology and the remainder to be distributed among the Executive Committee of the Manitoba Medical Association, in order that the report might be considered at the next meeting.

Report of Representative on Canadian Medical Association Executive.

Dr. Trainor gave an interesting report on the business transacted at the Canadian Medical Association Executive Committee meeting on March 13th and 14th at Toronto. He reported briefly on the financial statement, the code of ethics, salaries to state medical officials, committee on constitution and by-laws, honorary members, income tax abatements, and on osteopaths as examiners for life insurance.

Following Dr. Trainor's report, it was moved by Dr. O. C. Trainor, seconded by Dr. E. J. Skafel: THAT this report be accepted. —Carried.

The meeting adjourned.

OBITUARY

DR. ROBERT JONATHAN CRAWFORD

Dr. Robert Jonathan Crawford, aged 70, died at Winnipeg on June 8th. He graduated from Toronto University in 1891 and was licensed in 1893. He practiced for some time in Winnipeg but retired from practice several years ago.

DR. L. S. GENDREAU

Dr. L. S. Gendreau died at St. Norbert, Man., June 12th, in his 66th year. He was born in Quebec and received his early education in Montreal, graduating in Arts from Laval University. He came to Manitoba in 1893 and graduated in Medicine three years later. He practiced continually in St. Norbert until his retirement in 1937 on account of ill health. He is survived by his wife, one daughter and six sons, among whom are Dr. Philip Gendreau of Selkirk, Man., and Dr. Lionel of Ste. Rose du Lac, Manitoba.

DR. PERCY B. GRANT

Dr. Percy B. Grant died at Winnipeg on June 3. He was born at Granton, Ont., graduated in Medicine from the University of Manitoba in 1908 and practised for four years in Wawanesa before coming to Winnipeg.

MAJOR J. A. DEVINE

Major J. A. Devine died recently at Monte Carlo. He was born in 1869 at Toronto and was educated in England and Trinity College, Dublin. His practice in Winnipeg, begun in 1898, was interrupted by service as medical officer in the Boer War where he won the D.S.O. On his return to Winnipeg he became P.M.O. at Fort Osborne Barracks. He was the author of the play "Release of Allan Danvers" which brought the Earl Grey Trophy to Winnipeg for the first time. He lectured on Materia Medica and Therapeutics in the Manitoba Medical College. At the outbreak of the Great War he went to England and was assigned to hospital transports. After the war he practised in Monte Carlo.

NOTICE

The University of Wisconsin Medical School is to conduct an Institute for the Consideration of the Blood and Blood-Forming Organs, September 4-6, 1939. The program is to include papers and round-table discussions by European and American workers in the field of hematology. In addition to the discussions, the following formal papers are to be presented:

Dr. L. J. Witts, Oxford, England, Anemias due to Iron Deficiency.

Dr. Cecil J. Watson, Minneapolis, The Porphyrins and Diseases of the Blood.

Dr. Cornelius P. Rhoads, New York, Aplastic Anemia.

Dr. E. Meulengracht, Copenhagen, Denmark, Some Etiological Factors in Pernicious Anemia and Related Macrocytic Anemias.

Dr. Harry Eagle, Baltimore, The Coagulation of Blood.

Dr. George R. Minot, Boston, Anemias of Nutritional Deficiency.

Dr. Russell L. Haden, Cleveland, The Nature of the Hemolytic Anemias.

Dr. Jacob Furth, New York, Experimental Leukemia.

Dr. Claude E. Forkner, New York, Monocytic Leukemia and Aleukocythemic Leukemia.

Dr. Edward B. Krumbhaar, Philadelphia, Hodgkin's Disease.

Dr. Louis K. Diamond, Boston, The Erythroblastic Anemias.

Dr. Edwin E. Osgood, Portland, Marrow Cultures.

Dr. Charles A. Doan, Columbus, The Reticulo-Endothelial System.

Prof. Hal Downey, Minneapolis, Infectious Mononucleosis.

Dr. Paul Reznikoff, New York, Polycythemia.

Physicians and others who are interested are cordially invited. A detailed program may be obtained by addressing Dr. Ovid O. Meyer, Chairman of Program Committee, University of Wisconsin Medical School, Madison, Wisconsin.

NOTICE

Practice available Cypress River. For information write to Mr. S. Peters, Secretary-Treasurer, Cypress River Town Board, P.O. Box 66, Cypress River, Man.

Department of Health and Public Welfare

NEWS ITEMS

VENEREAL DISEASE

The following article is the second paper on this subject published by Dr. Alfred T. Osgood, Consulting Urologist, Bellevue Hospital, New York City, recently in the Publication "Preventive Medicine;" and also under "News Items" from the Department in the June issue of the "Review" the first article appeared. We are now including the second paper for your perusal.

—F.W.J.

THE PREVENTIVE ASPECTS OF VENEREAL DISEASES

"One of the crying needs is for financial backing of scientific research into all phases of the disease gonorrhea. Research in several directions would appear now to give promise of highly beneficial results. It has always been difficult to obtain philanthropic funds for the carrying on of investigation into this disease with its powerful taboo because of moral obliquity, and the prevalent idea that gonorrhea is an insignificant local infection.

"The way to be followed in the prevention and control of these diseases has been prepared by arduous investigation and planning on the part of physicians and numerous agencies for the public welfare. These inquiries have been successful in revealing to the public the enormous extent to which these diseases affect the population, their economic waste, their high indirect and direct mortality, the numerous cases which escape detection, the sources of infection which are undisturbed and which go on infecting others uncontrolled. The medical profession, hospitals, welfare and health agencies must undertake the vast labor of finding the cases, putting them under treatment by police control where necessary, checking and controlling all contacts with those already infected and keeping public opinion alive to its duty so that governmental authorities may proceed in the campaign with financial needs supplied and encouraging public backing.

"No physical examination is ever complete without a Wassermann test and a search for the signs and symptoms of these diseases. No child should be born without a test of the mother's blood. Each discovered case should be placed under medical care and held under treatment. Every suspicious contact with an infected person should be brought under medical observation and be examined for signs and symptoms of these diseases and treated as indicated.

"The problems within this subject of venereal diseases are intricate and complicated. Enlightened public health authorities are now in possession of the knowledge at least of the ways and means for their great limitation, working toward their prevention and control. But these methods cannot be put into force without very large resources of money and increased facilities for their administration. The laboratory facilities of the City of New York as at present organized could not deal with all of the cases that could readily be discovered by any concerted effort, so that both funds and facilities must be greatly expanded. The expenditures would pay large dividends in the health of the community within a very few years if this could be done.

"Beyond and above all the medical and governmental facilities for the control of these diseases, there are factors of great power to limit their spread which could be brought into play to far greater effect than has ever been done before. The influence of religious belief concerning bodily purity and virtue serves as one of the great deterrents against sexual promiscuity. This religious influence should be encouraged and promoted even by those who may not have such an anchor of belief. Education of the public which has been largely extended within the last few years should be expanded. Instruction concerning these diseases should especially be given to all those in the periods of life at which these diseases are most commonly encountered, that is, between the ages of 18 and 30. Mere knowledge concerning these diseases will certainly be a check to many. This knowledge should produce a perfectly proper and reasonable sense of fear. This fear of a disease of which the consequences are so dire is reasonable, intelligent. These and many other mental and emotional phenomena are prophylactics of superior value to all physical protectives.

"There must be an intensification of education of the medical profession. Every practitioner of medicine must find available the necessary laboratory facilities, and he should know at least when and how they are to be called upon. They should be available to him with competence and confidence in the laboratory. The specialist who concerns himself with the eye, or the ear, or the throat or the joints cannot be relieved of his responsibility and his duty to discover these diseases and do his full part in prevention and control. Ambulatory clinics and hospitals must be under rules and regulations, responsible to enlightened public health authorities for the proper management of these diseases if control and prevention are to be effective. The investigations carried out in this City concerning the standards of treatment of these diseases by clinics, some of them connected with reputable institutions, have given appalling evidence of the need for education of trustees as well as medical attendants because of woeful lack of observance of even minimum standards of medical practice.

"It is legally possible to control an infectious case. This apparently is not fully appreciated even by physicians. Restriction, even hospitalization under police powers, of those patients whoever they may be, in whatever economic or social status, who fail to comply with instructions, patients who neglect treatment through ignorance or shiftlessness, is possible, and these means should be applied vigorously to all classes of the infected if these diseases are to be brought into line with the control of infectious and communicable diseases.

"The interest, co-operation and support of the Public Health Relations Committee at the Academy of Medicine, the Bureau of Social Hygiene of the New York City Department of Health, the American Public Health Association, the Social Hygiene Committee of the New York T.B. and Health Association, and other welfare organizations are all actively engaged at this time in this city in a concerted effort to improve the medical service, teaching in medical schools, education of the layman, and to obtain financial support from governmental and private philanthropic funds, as well as to enlist the support of intelligent public opinion to carry forward a vigorous campaign for knowledge of as well as prevention and control of cases of these devastating venereal diseases.

"These activities should have the wholehearted support of all intelligent people, lay and professional, so that this may not be a sporadic effort but the beginning of an unrelenting fight for the limitation and eventual elimination of these diseases."

COMMUNICABLE DISEASES REPORTED
Urban and Rural — May 1st - 20th, 1939.

Occurring in the Municipalities of:

Mumps: Total 118—Winnipeg 107, Kildonan East 4, Kildonan West 2. Oak Lake Town 2, Morris Rural 1, Rockwood 1, St. Boniface 1.

Scarlet Fever: Total 56—Brandon 12, Winnipeg 10, Unorganized Territory 5, Turtle Mountain 4, Oakland 3, Shell River 3, Sifton 3, Portage Rural 2, Springfield 2, Cypress South 1, Fort Garry 1, McCreary 1, Saskatchewan 1, Swan River Rural 1, St. Boniface 1, St. James 1, St. Vital 1, Souris Town 1, Virden Town 1, Winchester 1 (Late Reported: Unorganized 1).

Whooping Cough: Total 50—St. James 12, Winnipeg 10, The Pas 9, Morris Rural 6, Hanover 1, Kildonan West 1 (Late Reported: Glenella 6, The Pas 4, St. Boniface 1).

Chickenpox: Total 42—Winnipeg 9, Brooklands 6, Flin Flon 6, Kildonan East 6, St. James 3, Piney 2, Cartier 1, Lorne 1, Louise 1, Rockwood 1, Rosser 1, St. Boniface 1, Unorganized Territory 1, Whitewater 1, Woodlands 1 (Late Reported: Brooklands 1).

Typhoid Fever: Total 36—Selkirk 30, St. Vital 1 (Late Reported: Selkirk 5).

Influenza: Total 34—Winnipeg 1, Louise 1 (Late Reported: Brandon 9, Unorganized Territory 3, Birtle Town 1, Garson Village 1, Gimli Rural 1, Gimli Village 1, Kildonan East 1, Morden Town 1, Morris Town 1, Norfolk North 1, Norfolk South 1, Pipestone 1, Portage City 1, Rhineland 1, Rockwood 1, Rossburn Rural 1, St. Boniface 2, Silver Creek 1, Victoria 2, St. Paul West 1).

Measles: Total 24—St. Boniface 9, Morden Town 5, Argyle 3, Swan River Rural 2, Thompson 2, Carman 1, Stanley 1, Unorganized Territory 1.

Diphtheria: Total 22—Winnipeg 17, Franklin 2, Hanover 1, The Pas 1 (Late Reported: De Salaberry 1).

Tuberculosis: Total 18—Winnipeg 14, Brandon 2, Springfield 1, Unorganized Territory 1.

Erysipelas: Total 12—Winnipeg 3, St. Vital 2, Kildonan East 1, Minitonas 1, Riverside 1, Ste. Anne 1, St. Boniface 1, Unorganized Territory 1 (Late Reported: Pembina 1).

Lobar Pneumonia: Total 10—Brandon 1 (Late Reported: Flin Flon 1, Hanover 1, La Broquerie 1, Minto 1, Montcalm 1, Rosedale 1, Russell Town 1, Selkirk 1, Victoria 1).

Diphtheria Carriers: Total 7—Winnipeg 7.

Cerebrospinal Meningitis: Total 2—Winnipeg 1, Flin Flon 1.

Smallpox: Total 2—Swan River Rural 2.

Trachoma: Total 1—Unorganized Territory 1.

German Measles: Total 1—Brandon 1.

Venereal Diseases: Total 137—Gonorrhoea 85, Syphilis 52.

DEATHS FROM ALL CAUSES IN MANITOBA
For the Month of April, 1939

URBAN—Cancer 37, Tuberculosis 11, Pneumonia (all forms) 7, Influenza 6, Lethargic Encephalitis 2, Diphtheria 1, Lobar Pneumonia 1, Typhoid Fever 1, Syphilis 1, all others under one year 12, all other causes 158, Stillbirths 10. Total 247.

RURAL—Cancer 29, Tuberculosis 18, Pneumonia (all forms) 16, Influenza 16, Lobar Pneumonia 4, Measles 2, Puerperal Septicaemia 1, Dysentery 1, all others under one year 32, all other causes 140, Stillbirths 15. Total 274.

INDIAN—Tuberculosis 9, Pneumonia (all forms) 4, Influenza 3, Lobar Pneumonia 1, Whooping Cough 2, all others under one year 10, all other causes 6. Total 35.